

ATI Real Life Student Packet
N202 Advanced Concepts of Nursing
2025

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ATI Scenario: CKD

To Be Completed Before the Simulation

Blue boxes should be completed using textbook information. What do you expect to find? This information should be collected before you start the ATI simulation

Medical Diagnosis: Chronic Kidney Disease

NCLEX IV (8): Physiological Integrity/Physiological Adaptation

Anatomy and Physiology
Normal Structures

The urinary system function is to filter blood and create urine as a waste by-product. The organs of the urinary system include the kidneys, renal pelvis, ureters, bladder and urethra. The body takes the nutrients from food and converts it to energy, after the body has taken the food components that it needs it creates the rest into waste products and leaves it in the bowel and blood. The kidneys help to eliminate the liquid waste called urea and keep the potassium, sodium and water balanced. The urea is produced when food containing protein are broken down in the body. Urea is carried in the blood stream to the kidneys. Where it is removed along with water and other waste in the form of urine. The kidneys remove the urea through tiny filters called nephrons, each nephron consisted of small blood capillaries called a renal tubule. (urine flows through the nephrons and down the renal tubules of the kidney) Ureters are the narrow tubes that carry the urine from the kidneys to the bladder.

The kidneys also have other functions such as regulation of blood pressure, the production of erythropoietin which helps control red blood cell production in the bone marrow. The kidneys also regulate the acid-base balance and conserve fluids.

The bladder is a hollow organ that is in the lower abdomen. The bladder has walls that relax and expand to store urine and contract and flatten to empty the urine through the urethra. The urethra is a tube that allows the urine to pass outside the body. The brain will signal the bladder muscles to tighten while squeezing out the urine out of the bladder.

NCLEX IV (7): Reduction of Risk

Pathophysiology of Disease

Chronic kidney disease is also called chronic kidney failure. This involves the gradual loss of kidney function. With advancing stages of CKD it can cause a dangerous level of fluid, electrolytes and waste to build up in the body. CKD is progressive and irreversible loss.

It is defined as one of the following:

1. Kidney damage (markers of damage)
2. Low GFR <60ml/min for 3 months or longer.

Staging is determined based on decrease of the GFR (glomerular filtration rate)

Normal GFR is 125ml/min (creatinine clearance)

Stage 1: kidney damage with normal GFR

Stage 2: Kidney damage with mild GFR (89-60)

Stage 3A: Mild to moderate GFR (59-45)

Stage 3B: Moderate GFR (46-30)

Stage 4: Severe GFR (30-15)

Stage 5: Kidney failure (<15 or dialysis)

To Be Completed Before the Simulation

Anticipated Patient Problem: Impaired Urinary Elimination

Goal 1: Patient will void at least 30ml/hr during my time of care.

Relevant Assessments	Multidisciplinary Team Intervention
(Prewrite) What assessments pertain to your patient's problem? Include timeframes	(Prewrite) What will you do if your assessment is abnormal?
Asses intake and output Q8hr (strict)	Administer diuretic per order (Lasix) during my time of care.
Assess urine characteristics q8hr or PRN (each time going to bathroom- color, odor	Encourage fluid intake via oral (water or cranberry juice) or IV during my time of care.
Assess tone of bladder, urinary problems (leaking while non-ambulatory) during my time of care	Educate and encourage the use of Kegel exercises q2hr during my time of care.
Assess patients normal voiding patterns qshift	Maintain patency of indwelling catheter PRN during my time of care.
Assess Lab values- K, BUN, GFR, Cr, Na,	Monitor and treat per lab value and symptoms that follow during my time of care.
Assess UTI risk during my time of care.	Encourage ambulation if tolerated q2hr (to facilitate bladder emptying to decrease risk of UTI's)

Goal 2: Patient will not progress to a worsening stage of CKD during my time of care. (GFR will not decrease further)

To Be Completed Before the Simulation

Anticipated Patient Problem: Fluid Overload (hypervolemia)

Goal 1: Patient will not have any signs of JVD, pitting edema in LE or elevated BP during my time of care.

Relevant Assessments	Multidisciplinary Team Intervention
(Prewrite) What assessments pertain to your patient's problem? Include timeframes	(Prewrite) What will you do if your assessment is abnormal?
Assess weight daily	Encourage taking weight in AM after morning void with only hospital gown on during my time of care.
Assess heart rhythm, HR q2hr	Maintain Tele monitoring during my time of care.
Assess RR and work of breathing q2hr	Administer oxygen as needed to maintain O2 greater than 90%
Assess urine output and intake q8hr	Administer Diuretics (Lasix) per order
Assess pedal pulses and cap refill and edema in LE during my time of care.	Encourage the use of EPC's daily during my time of care.
Assess K, Na, BUN levels	Encourage a low sodium diet, and fluid intake of 2,000ml/day during my time of care.

Goal 2: Patient will not have a weight gain greater than 2lbs/day during my time of care.

To Be Completed During the Simulation:

Actual Patient Problem:1. impaired urinary elimination

Clinical Reasoning: CKD, receiving peritoneal dialysis, GFR 8ml/min, BUN 42, Cr 8, UA cloudy with protein and blood present

Goal: A.S will void at least 30ml/hr during my time of care. Met: Unmet:

Goal: A.S will not progress to a worsening stage of CKD during my time of care. (GFR will not decrease further. Met: Unmet:

Actual Patient Problem: 2. Fluid overload- hypervolemia

Clinical Reasoning: weight gain of 6.6lbs in 2 days, SOB, Edema in LE

Goal: A.S will not have a weight gain greater then 2lbs/day during my time of care. Met: Unmet:

Goal: A.S will not have any signs of pitting edema in LE or elevated BP during my time of care. Met: Unmet:

Additional Patient Problems:

3. Deficient knowledge
4. Risk for decreased cardiac output/ risk for unstable blood pressure
5. Acute Pain
6. Impaired gas exchange
7. Ineffective coping
8. Enhanced readiness for health management

Below will be your notes, add more lines as needed. **Relevant Assessments:** Indicate pertinent assessment findings. **Multidisciplinary Team Intervention:** What interventions were done in response to your abnormal assessments? **Reassessment/Evaluation:** What was your patient’s response to the intervention?

Patient Problem	Time	Relevant Assessments	Time	Multidisciplinary Team Intervention	Time	Reassessment/ Evaluation
1,2,3	1630	Sent from nephrology clinic for hyperkalemia, receiving peritoneal dialysis for 9 months at home, weight gain of 6.6lbs in 2 days, Sob, edema in LE, stage V CKD, AV fistula placed-mature and ready for use, still has urine production HR 110, BP 170/92, RR 22,	1635	Admitted to Med-surg floor	1650	Resting in bed, eyes open, RR 24/min

				an illustration		
1,2,3	2020	“thanks for explaining, can you tell me some complications?” I’m a little confused, I’m not sure I understand	2025	Educated on risk for decreased BP during hemodialysis	2030	Verbalized understanding, provided teach back of complications during hemodialysis “low blood pressure”
1,2,3,4	2045	K 6 Cardiac monitoring #14, HR 114 Sinus tachycardia with peaked T waves	2100	Administered Calcium gluconate, Regular insulin, and 50% dextrose	2100	K 6
1,3	2100	Phosphorus 7.5	2110	Administered phosphate binder between meals	2120	Ongoing monitoring for muscle cramping, or development of tetany
1,2,3	2120	K 6	2120	Checked for presence of Chvostek sign	2125	Negative
1,2,6	2130	Furosemide 80mg IV bolus completed, K 6	2135	Urine output 60ml	2135	“Some improvement when I breath” + 2 pitting edem in LE
1,4	2240	BP 182/90, HR 112, 96% on 2L NC, RR18	2300	STAT administration of Labetalol 20mg IV bolus	2330	BP 168/88, HR 112
1,2,3	NEXT DAY 0715	Meds held for dialysis, AV fistula intact, bruit and thrill heard, Cap refill <3 secs in all extremities, +2 pitting edema in LE, +3 Pedal pulses, weakness on gait	0720	Educated on use of call bell if needing to get up due to weakness on gait	0720	“Ok ill push the button if I need to get out of bed”
5	1000	Headache 2/10 pain, fatigue, nausea, HR 88, Emesis 5ml, 30ml urine, BP 134/76	1000	Administered morning meds- Educated on reporting any muscle cramps, fatigue worsening, or chills	1230	“ok I’m going to rest now”
1,3,7	1300	Crying in chair, “this is so overwhelming, I	1305	Referral to case management, discussed ways to	1315	“thank you”

		just don't see the light at the end of this tunnel, sitting there for hours 3x a week is a waste of time"		minimize disruptions of normal routine.		
1,8	1500	SDHQ concerns for food security, cost of meds, ability to attend dialysis sessions	1520	Case management arranged van for transport	1525	It really helps, I'm "not worried as much"
1,8	AT HOME 1700	Grocery shopping, sodium restriction, fluid restriction of 1L/day, protein restriction, CKD, "I really like chili limes, baked sweet potatoes, sauteed onions, and tomato soup" "I don't know what to bring to my pot luck at my church"	1730	½ cup raw green peas for the sodium and potassium restrictions, and for potluck educated on healthy meal such as steamed broc, roasted chicken thighs and raw radishes.	1745	"that sounds great, Ill make that for the weekly pot luck, thank you"

To Be Completed After the Simulation

The orange boxes should be filled out with your simulation patient's actual results, assessments, medications, and recommendations

NCLEX IV (7): Reduction of Risk

Actual Labs/ Diagnostics
 Chest Xray-infiltration in all lobes
 Labs- K:6, BG174, BUN42, Phosphorus7.5,
 Hemoglobin10.2, hematocrit 32, WBC 14, Albumin
 3.2, A1C 7.4, Cr 8, GFR 8mL/min
 UA: cloudy, amber, protein of 80mg/dL,+1 blood

NCLEX II (3): Health Promotion and Maintenance

Signs and Symptoms
 SOB, Weakness, weight gain of 6.6 pounds in 2 days, LE edema,
 scattered rhonchi in all field of lungs, dyspnea on exertion

NCLEX II (3): Health Promotion and Maintenance

Contributing Risk Factors
 Kidney disease
 Being hospitalized
 Advanced age
 Blockages in blood vessels (PAD)
 DM
 HTN
 HF
 Liver disease

NCLEX IV (7): Reduction of Risk

Therapeutic Procedures
Non-surgical
 Dialysis

Surgical

Prevention of Complications
 (Any complications associated with the client's disease process? If not what are some complications you anticipate)
 Fluid buildup
 Chest pain/CVD
 Muscle weakness
 Death

NCLEX IV (6): Pharmacological and Parenteral Therapies

Medication Management
 Losartan 50mg Po
 Furosemide 20mg Po
 Gabapentin 100mg PO 3x/day
 Atorvastation 20mg PO
 Gentamicin ointment 2x daily
 Ferric citrate 1g Po 3x with meals
 Linagliptin 5mg PO daily
 Aspirin 81mg Po daily

NCLEX IV (5): Basic Care and Comfort

Non-Pharmacologic Care Measures
 Limit fluid intake
 Comfort-positioning

NCLEX III (4): Psychosocial/Holistic Care Needs

Stressors the client experienced?
 Confusion
 Fear
 Lack of knowledge

Client/Family Education

Document 3 teaching topics specific for this client.
 •Educate on importance of healthy lifestyle, eating balanced diet and being active.
 • Encourage client to treat any underlying conditions such as HTN, DM to reduce the risk of death/condition worsening.
 • Educate on overuse of OTC medications such as aspirin, ibuprofen, or Tylenol.

NCLEX I (1): Safe and Effective Care Environment

Multidisciplinary Team Involvement
 (Which other disciplines were involved in caring for this client?)
 Nephrology
 Urology
 MD
 Nurses
 Dietary
 Surgeon (fistula or central line placement if stat dialysis needed)
 Dialysis nurse
 Case management

Patient Ressources

Case management
 Dialysis
 Transportation- van, SDHQ

Reflection Questions

Directions: Write reflection including the following:

1. What was your biggest “take away” from participating in the care of this client?
My biggest take away from participating in the care of this client is that even though someone may look like they are able to provide for themselves, doesn't always mean they can. Some people are very shy in asking for help or saying that they can't afford things so the questionnaire isn't just a piece of paper or box to check off that you completed, it truly could change the outcome of someone's medical attention and care they receive by simply taking a second and reading what your patients write and asking questions and showing empathy to their answers.
2. What was something that surprised you in the care of this patient?
One thing that surprised me in the care of the patient was the lack of knowledge and confusion while going through treatments already. I felt as if she should have been informed and educated along the way rather than waiting for something big to happen such as admission to the hospital to learn what is truly happening and what the next steps are.
3. What is something you would do differently with the care of this client?
Something I would do differently in the care of this client is to have resources available to her a lot sooner than she received them, we could have potentially avoided her recent hospital admission if we would have had dietary and home health visits sooner to get her diet under controlled and managed. A simple few questions could he prevented the admission and allow her to be educated sooner on her health management.
4. How will this simulation experience impact your nursing practice?
This simulation experience will impact my nursing practice because I will take the time to know if my patients need help at home, yes my job is to take care of them while in the hospital but its reaches further then just in the hospital walls. Asking my patients the simple questions regarding food security and affordable health care management such as medications can truly make a difference in the outcome of a medical diagnosis. Advocating for my patient when they don't have something they need and finding the resources for them.